VOL. 4, No. 10 OCTOBER 1950

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

CONTENTS

	Page
Drug nomenclature and standards : sixth session of the Expert Committee on the Unification of Pharmacopoeias	301
Child health : fourth session of the Joint Committee on Health Policy, UNICEF/WHO	304
Incidence of poliomyelitis, 1947-1949	307
Mortality in Europe	309
Chemotherapy of trachoma	310
Epidemiology of Q fever	312
Bilharziasis in the Pacific	313
Plague control in Taranto, Italy, in 1945	315
DDT and sandflies	316
Determination of small amounts of residual DDT	316
Serodiagnosis of the typhus group of fevers : standardization of tests	317
Diagnosis of typhoid and paratyphoid A and B fevers : standardization of agglutination tests	318
Standardization of liver extracts	319
Antigens in serodiagnosis of syphilis	320
Psychiatric examination of offenders	320
Reports from WHO Fellows	
Mexican National Institute of Cardiology	322
Notes and News	
Dr Pierre Dorolle	323
Poland decides to withdraw from WHO	324
Manual for tuberculosis control workers	325
Spanish and French editions of the *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*	325
Views on WHO	
Challenge of malnutrition	326
Mental health	326

RECENT AND FORTHCOMING MEETINGS

1950

1-10 June	WHO Executive Board, sixth session, Geneva
7-12 August	WHO Expert Committee on School Health Services, first session, Geneva
28 August-2 September	Joint ILO/WHO Committee on Occupational Hygiene, first session, Geneva
4-7 September	WHO Regional Committee for the Eastern Mediterranean, third session, Istanbul
8-9 September	WHO Regional Conference on Statistics, Istanbul
11-16 September	WHO Expert Committee on Mental Health, second session, Paris
11-16 September	WHO Expert Committee on Tuberculosis, fifth session, Geneva
22-26 September	WHO Regional Committee for South-East Asia, third session, Kandy, Ceylon
23 September-2 October	WHO Expert Committee on Venereal Infections: Subcommittee on Serology and Laboratory Aspects, second session, Paris
25-30 September	WHO Regional Committee for the Americas, second session ; Pan American Sanitary Organization Directing Council, fourth meeting ; Ciudad Trujillo
4-11 October	WHO Expert Committee on Insecticides, second session, Geneva
9-18 October	WHO Expert Committee on International Epidemiology and Quarantine, third session, Geneva
30 October-4 November	WHO Expert Committee on the Unification of Pharmacopoeias, seventh session, Geneva
6-11 November	WHO Expert Advisory Panel on Brucellosis, Washington
6-11 November	WHO Expert Committee on Biological Standardization, fourth session, Geneva
27 November-9 December	WHO Malaria Conference in Equatorial Africa, Kampala, Uganda
December	WHO Expert Committee on Public-Health Administration, first session, Geneva
11-16 December	WHO Expert Committee on Malaria, fourth session, Kampala, Uganda

1951

22 January	WHO Executive Board, seventh session, Geneva
7 May	Fourth World Health Assembly, Geneva

DRUG NOMENCLATURE AND STANDARDS

Sixth Session of the Expert Committee on the Unification of Pharmacopoeias

Discussion of the reports and of the draft monographs prepared for the addendum to the *Pharmacopoea Internationalis* were the principal items on the agenda of the sixth session of the Expert Committee on the Unification of Pharmacopoeias, held in New York from 20 to 29 April 1950.[1]

During the session the committee also studied the setting-up of some mechanism for assigning non-proprietary names to drugs and examined various other problems, including drug control and fellowships.

Pharmacopoea Internationalis (Ph.I.) and Addendum

The final details were settled for the simultaneous publication in English and French of the first edition of the *Pharmacopoea Internationalis* ; a Spanish translation, based on the English and French versions, will be prepared later.

The World Medical Association had communicated to the committee its opinions concerning the table of doses ; and the International Union of Chemistry had approved the graphic and chemical formulae.

---

[1] This following took part in this session :

Members :

Dr H. Baggesgaard-Rasmussen, Professor of Pharmaceutical Chemistry, Danish School of Pharmacy, Copenhagen, Denmark ; Member of the Danish Pharmacopoeia Commission

Professor E. Fullerton Cook, Pharm.D., Chairman, Committee of Revision of the Pharmacopoeia of the United States of America, New York City, N.Y., USA (*Vice-Chairman*)

Dr I. R. Fahmy, Professor of Pharmacognosy, Fouad I University, Cairo, Egypt ; Secretary, Egyptian Pharmacopoeia Commission

Dr H. Flück, Professeur de Pharmacognosie à l'Ecole Polytechnique Fédérale, Zürich, Switzerland ; Membre de la Commission fédérale de la Pharmacopée

Dr C. H. Hampshire, Secretary, British Pharmacopoeia Commission, General Medical Council Office, London, United Kingdom (*Chairman*)

Dr R. Hazard, Professeur de Pharmacologie et de Matière médicale à la Faculté de Médecine de l'Université de Paris, France ; Membre de la Commission permanente du Codex

Dr D. van Os, Professor of Pharmaceutical Chemistry and Toxicology, University of Groningen, Netherlands ; Chairman, Netherlands Pharmacopoeia Commission

Co-opted Members :

Dr D. Mayoral Pardo, Professor of Pharmacology and Therapeutics, Faculty of Medicine, National University of Mexico, Mexico D.F. ; Chairman, Committee of Revision of the Mexican Pharmacopoeia

Dr C. A. Morrell, Director, Food and Drugs Divisions, Department of National Health and Welfare, Ottawa, Canada ; Chairman, Canadian Committee on Pharmacopoeial Standards

Representative of the United Nations :

C. Fulton, Division of Narcotic Drugs, Department of Social Affairs, Lake Success, N.Y., USA

Observers :

Dr L. Miller, Director-Elect, Committee of Revision of the Pharmacopoeia of the United States of America, New York City, N.Y., USA

T. Rosin, Ph.M., Member of the Committee of Revision of the Pharmacopoeia of the United States of America, New York City, N.Y., USA

Dr R. I. Stormont, Secretary, Council on Chemistry and Pharmacy, American Medical Association, Chicago, Ill., USA

Secretary :

P. Blanc, Chief, Pharmaceutical Section, WHO

The report of the committee will be published as *World Health Organization : Technical Report Series*, **29.**

FIG. 1. EXPERT COMMITTEE ON THE UNIFICATION OF PHARMACOPOEIAS, SIXTH SESSION

Left to right, seated : Dr I. R. Fahmy ; Professor E. Fullerton Cook (Vice-Chairman) ; Dr. C. H. Hampshire (Chairman) ; Dr H. Baggesgaard-Rasmussen ; standing : Dr C. A. Morrell (co-opted member) ; Dr D. Mayoral Pardo (co-opted member) ; Dr D. van Os ; Dr H. Flück ; Dr R. Hazard ; P. Blanc (WHO)

Members of the committee and co-opted members made statements on the probable attitudes of their governments to the first international pharmacopoeia. It is expected that Canada, which has as yet no real pharmacopoeia, will establish one, probably using the Ph.I. as a basis. In Denmark, a revised edition of the Danish pharmacopoeia has recently been published, and the titles and standards of the Ph.I. will be adopted wherever possible in the addendum now under preparation. Ph.I. titles and standards will be adopted in the edition of the Egyptian pharmacopoeia which is to appear shortly. The US pharmacopoeia will adopt the titles as titles or synonyms except in cases where proprietary names already exist ; the international reference standards will continue to be adopted, as hitherto, in so far as applicable. The new edition of the French Codex will incorporate as many of the Ph.I. monographs and standards as possible. A second edition of the Mexican pharmacopoeia has just been issued ; subsequent editions will probably adopt Ph.I. standards. In the Netherlands, the Ph.I. titles are already in use and the standards will also be adopted as far as possible. The British pharmacopoeia in its next edition will conform to the Ph.I. except for certain details. The Swiss pharmacopoeia already includes some of the titles and standards in the second supplement to its fifth edition ; a larger number of these will probably be included in the sixth edition, which is being prepared.

The first edition of the Ph.I. deals chiefly with the drugs most commonly in use, and to complement it, the publication of an addendum is envisaged for the end of 1951. A great number of meetings during the session were devoted to the examination of some of the two hundred or so monographs to be included in the addendum. These cover the principal antibiotics and new products whose value has been proved. Injections and tablets are included, and a table of posology for children, so far provided by only very few national pharmacopoeias, will be inserted. It is also probable that new methods of analysis, such as chromatography, colorimetry, polarography, and spectrophotometry will be included.

List of Synonyms

The committee studied a list of synonyms for the drugs included in the Ph.I. as well as for certain other important drugs and recommended that this list be published at the same time as the Ph.I., in the form of a supplement to the *Bulletin of the World Health Organization.*

Non-Proprietary Names for New Drugs

The general principles relating to the establishment of a system of non-proprietary names for drugs, as discussed during the preceding session, had been communicated to Member States. A considerable number of governments have replied, expressing great interest in the plan. In the course of the sixth session, the committee endeavoured to work out a mechanism which would make it possible to give non-proprietary names to new drugs rapidly, if possible before they were available commercially. This question presents difficulties, and the committee was of the opinion that no system could be perfect since in all countries a great number of proprietary names already existed. It would be easy, therefore, to find new non-proprietary names which all countries would accept as the common nomenclature. Nevertheless, the present situation would be improved and the existing confusion reduced if WHO were to introduce some appropriate mechanism on an international level.

After discussion, during which information was given on the methods adopted in various countries for the introduction of non-proprietary names, the committee proposed the following procedure :

The national pharmacopoeia authorities or any other bodies concerned with the establishment of non-proprietary names in the various countries should be requested to notify WHO of important new drugs for which it would be advisable to find common names for national and international use. Drug manufacturers, research laboratories, and administrations controlling pharmaceutical products should also be invited to notify either

their own competent authorities or WHO directly with regard to any new products for general use likely to be placed on sale internationally. A subcommittee of three members, elected from the Expert Committee on the Unification of Pharmacopoeias, should be responsible for decisions concerning names to be used. The name selected would be communicated to Member States and competent national authorities with a recommendation concerning its adoption on the national level.

Control of Drugs

A questionnaire is to be sent to Member States so that a complete documentation may be assembled to enable WHO to supply any information required on the establishment of pharmacopoeias or the control of drugs. The committee specified the points to be included in the questionnaire. These covered regulations in force as to compliance with pharmacopoeial standards, any regulations providing standards for drugs not included in the pharmacopoeia, regulations concerning labelling and advertising, any differences between standards required for drugs manufactured in the country and imported drugs, and regulations with regard to the control and periodical inspection of pharmacies.

CHILD HEALTH

Fourth Session of the Joint Committee on Health Policy, UNICEF/WHO

The Joint Committee on Health Policy of the United Nations International Children's Emergency Fund (UNICEF) and WHO held its fourth session in Geneva on 30 and 31 May 1950.[1]

The following is a summary of the decisions reached on the chief items on the agenda.

International Children's Centre

The 1950-1951 programme of the International Children's Centre in Paris (referred to in an earlier number of the *Chronicle* [2]) was approved in principle by the joint committee. The Director-General stated to the committee that he had already given his technical approval for three

[1] For list of participants see page 306.

[2] *Chron. World Hlth Org.* 1949, 3, 240

projects, concerning : a course on social paediatrics ; the BCG pilot station ; and immunology research. Among other projects proposed for the Centre which were being studied by WHO preparatory to being given technical approval are those concerning : a course on child social psychiatry ; a course on tuberculosis in children ; and the question of " hospitalization and separation of nursing babies from the family environment ".

The social paediatrics course brought together this year 69 fellowship holders from 29 countries. The course on tuberculosis in children, which is an innovation, is expected to be held towards the end of 1950 and will be given to about 20 participants from various countries. The course on child social psychiatry is also new ; it stresses the importance of studying the intellectual and mental development of children from early infancy, as well as psychological disturbances and their prevention. In particular this course deals with the latest pedagogical methods, factors leading to criminality, the role of psychosomatic medicine in paediatrics, the care of maladjusted children, and the detection of backwardness in schoolchildren.

The research section of the Centre is studying two main subjects during this period : immunology phenomena during foetal development, and problems concerning BCG (BCG Pilot Station). The object of the immunological research is to study the relation of congenital deformities to certain infections of the mother. For example, congenital cataract—the result of deterioration in the crystalline lens of the eye of the foetus following an attack of rubella in the mother—will be studied experimentally.

The BCG Pilot Station in Paris makes a systematic study of many practical questions on BCG vaccination. It was particularly concerned with the tuberculin and vaccine used by the Joint Enterprise and UNICEF in the mass vaccination campaigns carried out in Europe with products from the Institut Pasteur in Paris and the Statens Seruminstitut in Copenhagen.

Dry BCG vaccine, a subject of immediate importance and one on which opinions are divided, is also to be studied. The research section will continue its work on the relative effectiveness of crude and purified tuberculin for tuberculin tests, new data being continually supplied by tuberculin sampling.

Research work on nutrition and on antipertussis vaccination, which comes within the general programme of activities of the Centre, will not be undertaken during this first period.

All-India Institute of Hygiene and Public Health

The committee considered and approved the proposal for the establishment at the All-India Institute of Hygiene and Public Health, Calcutta, of a maternal and child health section, for the training of child health workers. Provision will also be made for 250 fellowships available to students from other countries in the area.

Insecticides

The committee approved of financial aid by UNICEF for the establishment of insecticide manufacturing plants in non-producing countries. The use of insecticides in the control of various insect-borne diseases is an important factor in the improvement of child health ; it is known that mosquito- and fly-control by insecticides with a residual effect has already resulted in an appreciable decline in infant mortality in many parts of the world.

Antibiotics

The committee approved the allocation of UNICEF funds for improving the production of antibiotics, particularly streptomycin, crystalline penicillin, aureomycin, and chloromycetin. Such assistance will make it possible to modernize and extend existing installations, to set up new ones, and to develop research on antibiotics in selected areas, in accordance with the recommendations of the WHO Expert Committee on Antibiotics.

LIST OF PARTICIPANTS

Members :

UNICEF

Dr L. Rajchman, Chairman, Executive Board, UNICEF, New York, USA
Professeur R. Debré, Chairman, Medical Subcommittee, UNICEF ; Président du Centre international de l'Enfance, Paris, France (*Chairman*)
Dr J. Holm, Chief, Tuberculosis Division, Statens Seruminstitut, Copenhagen, Denmark
Dr W. B. Sutch, Acting Chairman, Executive Board, UNICEF ; Chairman, Subcommittee on Finances and Budget, UNICEF, New York, USA

WHO

Dr M. Mackenzie, Principal Medical Officer, Ministry of Health, London, United Kingdom
Dr J. A. Höjer, Director-General of Public Health, Stockholm, Sweden
Dr H. van Zile Hyde, Medical Director, US Public Health Service, Washington, D.C., USA
Dr A. Stampar, President, Yugoslav Academy of Sciences and Arts ; Professor of Public Health and Social Medicine, University of Zagreb, Yugoslavia

Alternates :

WHO

Dr C. van den Berg, Director-General for International Health Affairs, Ministry of Social Affairs, The Hague, Holland
Dr H. S. Gear, Deputy Chief Health Officer for the Union of South Africa, Cape Town, Union of South Africa

Secretaries :

UNICEF

Dr B. Borčić, WHO Liaison Officer, UNICEF, Paris, France

WHO

Dr D. A. Messinezy, Medical Officer, Office of the Assistant Director-General, Department of Advisory Services

Also present :

Dr R. Gautier, Director of Research, International Children's Centre, Paris, France

Dr C. K. Lakshmanan, Director, All-India Institute of Hygiene and Public Health, Calcutta, India

Dr C. Palmer, Director, Tuberculosis Research Office, WHO, Copenhagen, Denmark

Secretariat :

UNICEF

Mr M. Pate, Executive Director, UNICEF, New York, USA

Mr A. E. Davidson, Director, UNICEF European Office, Paris, France

WHO

Dr Brock Chisholm, Director-General

Dr M. Eliot, Assistant Director-General, Department of Advisory Services

Mr M. Siegel, Assistant Director-General, Administration and Finance

Mr H. Bosch, Chief, Environmental Sanitation Section

Mr J. W. Wright, Secretary, Expert Committee on Insecticides

INCIDENCE OF POLIOMYELITIS, 1947-1949

The world distribution of poliomyelitis and the factors causing epidemic outbreaks of the disease are little known at present. Despite the very extensive literature published during the last fifteen years on the various aspects of poliomyelitis, only slight progress has been made as far as knowledge of its epidemiology is concerned. Furthermore, when it is remembered that non-paralytic poliomyelitis is practically never diagnosed except during epidemics and that even classical poliomyelitis is hardly ever reported in regions with a shortage of physicians, it can be seen that the extent of present knowledge concerning the geographical distribution of poliomyelitis is very limited.

The latter observation is of importance since it explains why, as shown by the statistics, there is a marked lack of balance in the notifications of poliomyelitis from different areas. Thus, notifications for Africa in 1949 amount to scarcely half of those for France during the same year. For 1948, the number of reported cases of poliomyelitis for the whole of Central and South America is less than 80% of the notifications for Canada alone.

The last general study of the distribution of poliomyelitis in the world was published in 1947 by K. Stowman in the *Epidemiological and Vital Statistics Report*.[1] In a recent issue of the same publication,[2]

[1] *Epidem. vital Stat. Rep.* 1947, **1**, 114 ; see also *Chron. World Hlth Org.* 1948, **2**, 25.

[2] *Epidem. vital Stat. Rep.* 1950, **3**, 3

Dr M. J. Freyche, Chief of the Epidemiological Information Section of WHO, has dealt with the distribution of poliomyelitis from 1947 to 1949.

Europe and USA

As regards poliomyelitis, the years 1945 for the USA and 1946 for Europe can be considered as relatively " normal ". Thus, in the USA the number of cases reported for 1945 corresponds to the median number of figures recorded from 1942 to 1948. However, in 1946 the number of cases reported—25,191—exceeded, by 9,500 and 6,000 respectively, the figures for those years during the period 1926 to 1945 when the endemic level was highest, i.e., the years 1931 and 1944. In 1948, 27,667 cases were reported, representing a new increase of 10% over 1946. In 1949 there was an unprecedented increase in poliomyelitis in the USA, the number of cases reaching 42,375, an increase of 209% over the median number of cases reported between 1942 and 1948. The incidence of the disease, however, varied considerably in the different States.

The 1946 epidemic in the USA was followed by a similar outbreak in Europe in 1947, more than 29,000 cases being registered in the latter year, thus exceeding the 1946 figure by 140%. In 1948, the number of cases was 33% less than in 1947, with the exception of a few countries only. From 1948 to 1949 the number of cases rose from 19,622 to 20,374. In 1949 in certain countries, France and Iceland for example, the figures were the highest recorded; in the United Kingdom the figure was the second highest, and in Sweden the third highest. In France, the 1949 epidemic is considered the most severe in 20 years. It was characterized by the wide dispersion of the cases and the apparent absence of any connexion between them. In England and Wales, the 1949 epidemic was, after that of 1947, the worst one recorded during the past 25 years. The whole of the country was affected, the most pronounced increase being reported in the south-west.

Other Areas

The data for the American continent apply mainly to North America. Notifications from other areas are not sufficient for conclusions to be drawn from them, and in certain countries they are totally lacking for 1949. In Canada, the third highest number of cases was observed in that year.

In Africa, the number of poliomyelitis cases notified in 1949 represented only half of those reported for France alone ; 80% of the figures come from the Belgian Congo, Kenya, Tanganyika, and the Union of South Africa.

The highest figures in Asia were reported by Japan. The other data are too fragmentary and incomplete for any conclusion to be drawn. As

regards India, however, Dr N. Kezerian, who was in charge of a WHO team there,[3] states that 20% of infirmities among children there can be attributed to poliomyelitis. In New Zealand, the second highest number of cases occurred in 1948, the epidemic which had broken out at the end of 1947 continuing until April 1949. In Australia, the epidemic appeared later, and the incidence in 1949 is considered the highest since 1939.

The causes of the irregular appearance of poliomyelitis in the world and of the epidemic outbreaks will perhaps be explained only after epidemiological and immunological research has been carried out in different parts of the globe. The incidence of cases according to sex, age, and profession should also be studied.

[3] *Chron. World Hlth Org.* 1950, **4**, 63

MORTALITY IN EUROPE

A first contribution to medical statistical documentation on mortality by cause, sex, and age throughout the world was recently published in the *Epidemiological and Vital Statistics Report* ;[1] the information is presented in tabular form, preceded by explanatory notes by Dr M. Pascua, Acting Director of the WHO Division of Health Statistics.

These tables give the most recent information available on mortality in a certain number of European countries, the data being classified according to cause of death, age-group, and sex. Additional information is also given concerning the number of live births (classified by sex) and the corresponding population figures for the respective countries (classified by sex and by age-group). This will make it possible to calculate specific death-rates without difficulty.

In his introduction, Dr Pascua recalls that the publication of mortality statistics is one of the duties assigned to WHO by its Constitution, such publication having been explicitly recommended by the WHO Expert Committee on Health Statistics at its first session in May 1949. This documentation, dealing with a few European countries, serves to initiate a series which will eventually include all countries throughout the world which can supply similar information on mortality by cause. Furthermore, the data available at present will be incorporated in the general study dealing with the evolution of mortality in Europe during the twentieth century, the second part of which has just appeared.[2]

[1] *Epidem. vital Stat. Rep.* 1949, **2**, 192
[2] *Epidem. vital Stat. Rep.* 1950, **3**, 30

The compilation of such data has a twofold interest. These statistics can be of immediate value in the establishment of health programmes by the appropriate administrations. Moreover, they will make it possible to appreciate the changes which the various mortality factors undergo in different countries in the course of years ; they will offer a unique opportunity for evaluating, on an international scale, the evolution of the phenomena which affect mortality-rates.

CHEMOTHERAPY OF TRACHOMA

Since shortly after their discovery, the sulfonamides have been used successfully in the treatment of trachoma ; today they occupy a leading place in the chemotherapy of this disease. However, the antibiotics are becoming increasingly important ; the use of aureomycin and chloromycetin, in particular, has recently been the object of some very interesting work.

What is the place to be assigned today to each of the therapeutic means at the disposal of the ophthalmologist? By what criteria is he to be guided in his choice ? To attempt to answer these questions, Dr M. J. Freyche, acting Chief of the Epidemiological Information Section of WHO, has just published in the *Bulletin of the World Health Organization*[1] a general study of the treatment of trachoma by sulfonamides and antibiotics, basing his article on the abundant literature which has appeared on this subject.

Even though sulfonamide therapy alone may not effect the absolute " cure " which certain medical men have claimed, it does make possible the control of infectious conjunctivitis, which provides a favourable ground for trachoma ; thus the risk of contagion is reduced. This prophylactic action, together with clinical improvements, is sufficient to justify the use of sulfonamide therapy in the absence of a truly specific remedy. However, the sulfonamides are not always innocuous, as is proved by the cases of intolerance which demand a temporary suspension of the treatment, or its discontinuance. One of the disadvantages of the sulfonamides is that the dosage which gives the best results in the treatment of trachoma—weak doses administered over a long period—is also the dosage which causes the most trouble. Nevertheless, provided certain precautions are taken, it is now possible to carry out mass treatment of trachoma by sulfonamides if medical staff and well-equipped laboratories are available.

The author points out, however, that, in spite of the numerous successes recorded, there are also frequent failures. If the disappearance of hyper-

---

[1] *Bull. World Hlth Org.* 1950, **2**, 523

plastic conjunctival lesions is to be taken as the criterion of cure, it must be admitted that in 30% to 40% of cases these lesions are only slightly, if at all, modified by the treatment.

After having given the indications, advantages, and drawbacks of local and oral administration of the sulfonamides, Dr Freyche describes their mode of action, which is still the subject of much discussion. Some authors consider that these drugs have only a bacteriostatic action on the conjunctival flora and not a specific action on the virus. Clinical observations and experiments on the mouse, on the other hand, would seem to prove that the sulfonamides act, in reality, on the etiological agent of trachoma. Recent progress in the culture of the virus may perhaps soon provide the solution to this problem.

The second part of Dr Freyche's study is devoted to the antibiotics. Six commercially prepared antibiotics have been tried in the treatment of trachoma. The results obtained by various workers with tyrothricin are not in agreement. This antibiotic does not appear to be a specifically therapeutic agent but is a good local antiseptic. Gramicidin S has been employed with some success, particularly by Russian authors. Penicillin, unlike the previously mentioned substances, may provoke considerable allergy. On account of the very frequent doses which must be given, it is not suitable for mass treatment of the disease, and it also may be considered more as an auxiliary drug. Streptomycin, which has the disadvantage of being toxic and which has little effect on the virus, is a therapeutic agent of secondary value only. Bacitracin does not yet appear to have been tried.

Aureomycin and chloromycetin are of particular interest. The former has been used with some success in Italy, Portugal, Uganda, and the USA. The observations with regard to it are still too limited, however, to permit drawing definite conclusions. Because of its action against certain viruses and rickettsioses, hopes have been raised with regard to chloromycetin. Encouraging experiments have been reported, some of which demonstrate that chloromycetin, administered orally, acts against trachoma. This fact, if confirmed, will be of considerable importance.

In discussing the value of the observations assembled to date, Dr Freyche indicates the main lines of the therapy which ophthalmologists will have to adopt, according to the facilities available to them (staff, laboratory, hospital). A table, drawn up in accordance with Bietti's data, summarizes present knowledge concerning the action of chemical agents and antibiotics in the treatment of trachoma.

EPIDEMIOLOGY OF Q FEVER

Since the discovery of Q fever by Derrick in 1935, the study of this disease has progressed satisfactorily in spite of its complex nature. In an article published in the *Bulletin of the World Health Organization*,[1] Dr M. M. Sidky, former medical officer of the Epidemiological Studies Section of WHO, distinguishes three distinct phases in the history of Q fever, corresponding to the epidemiological manifestations of the disease in Australia, the USA, and the Mediterranean area.

Australia

In 1935 there were a number of cases of fever among the personnel in a meat-works in Brisbane (Queensland). Derrick, after studying the infection, came to the conclusion that it constituted an unidentified nosological entity and proposed that it be called " Q fever ". Symptoms of the disease were headache and comparatively slow pulse, and it differed from other fevers in that there was no characteristic exanthema. Guinea-pigs injected with the blood or urine of patients were receptive to the infection. Later, Burnet and Freeman succeeded in isolating rickettsial bodies in the spleen of mice inoculated with the liver of infected guinea-pigs. In addition, specimens of serum from a patient showed an increase in agglutinating titre with a rickettsial suspension. These two findings seemed conclusive evidence of the etiological rôle of the rickettsia, and the causative organism was named *Rickettsia burneti*.

Since the original epidemic had affected every occupational group in a meat-works, the source of infection was sought in livestock and its parasites. Research revealed the existence, in the first place, of a cycle of infection of which the bandicoot and other wild animals are the reservoir and certain ticks—*Ixodes holocyclus*, for example—the vector. Cattle harbour ticks and may be infected by bites. Infection may be transmitted to man directly by tick bites, but it is generally produced by contact with the tissues and organic fluids of the cattle or by inhalation of dust made of tick excreta.

USA

While in Australia clinical studies were made before the search for vectors began, in the USA the pathogenic agent was discovered before cases of fever were observed ; in fact, it was in the laboratory that rickettsiae were isolated from ticks. The study of these rickettsiae showed that they

[1] *Bull. World Hlth Org.* 1950, **2**, 563

were closely related to those discovered in Australia and, for this reason, the name of *R. burneti*, subsp. *diaporica* was given to them. Most of the cases of fever occurred among laboratory workers, among whom the infection was probably caused by inhalation of infected dust. Frequent pulmonary complications were observed.

Mediterranean Area

In the Mediterranean region, Q fever, which was characterized there also by pulmonary complications, was first discovered in the armed forces. Investigation showed that a disease previously classified as " atypical pneumonia " or " Balkangrippe ", was, in reality, Q fever. The etiological agent, *R. burneti*, was not isolated until 1945 ; it was not possible, however, to determine with certainty the origin of the infection.

Recent Outbreaks

Q fever has appeared in various parts of the world during recent years ; cases break out not only in laboratories, abattoirs, and meat-works, but also in dairies. Milk would therefore seem to constitute a new source of infection. In fact, it has recently been demonstrated that the disease may be transmitted, without intervention of parasites, by infected cows' or goats' milk.

BILHARZIASIS IN THE PACIFIC

Bilharziasis is one of the most widespread diseases in the world. In particular, it is endemic in the coastal areas and islands of the Pacific : there are 33,000,000 cases in China, 174,000 in Japan, 250,000 in the Philippines, and 1,000 in Celebes. These estimates are given by Dr Willard H. Wright, Chief, Laboratory of Tropical Diseases, Microbiological Institute, National Institutes of Health, Bethesda, Md., USA, in an article which recently appeared in the *Bulletin of the World Health Organization*.[1] The author gives in tabular form data on the number of infected persons in the various districts of those countries where the disease is prevalent.

Despite its high incidence, the importance of bilharziasis as a public-health problem has not been sufficiently appreciated. It is frequently overlooked because of the similarity of its symptoms to those of other

[1] *Bull. World Hlth Org.* 1950, 2, 581

diseases ; it is often masked by certain other diseases, such as malaria, dysentery, or nutritional deficiences.

The US armed forces stationed on Leyte in 1944 did not escape unscathed ; 1,700 cases and two deaths were recorded. The cost of treatment and hospitalization amounted to $3,000,000, not to mention losses due to incapacitation.

Among native populations, repeated infection gives the disease a chronic form. Weakened by multiple lesions of the digestive tract, patients often die from intercurrent infections.

The snails which act as intermediate hosts for the parasite have been described under many different names. However, it would seem that they all belong to a single genus, *Oncomelania*, which includes several species and subspecies. Dr Wright's article includes a table giving the various names of these snails, the countries where they are found, the authors describing them, and the corresponding bibliographical references.

The last part of Dr Wright's study deals with the control of bilharziasis. This raises complex problems since, in each region, agricultural methods, economic conditions, and the habits of the people must be taken into account. In almost all endemic zones, bilharziasis is predominantly a disease associated with rice-farming. The use of human excreta for fertilizing the soil contributes to maintaining the infection in China and, perhaps, in certain parts of Japan. It seems unlikely, however, that these practices could be altered. In the Philippines the custom of washing clothes and bathing in infested water is an important factor in the transmission of the disease. In Japan, animals which harbour the parasite (horses, goats, dogs, various rodents) play some part in spreading infection ; according to certain authors, it is possible that oxen and buffalo also help to spread the disease.

There are various methods of control, including the destruction of schistosome ova in night soil, the removal of vegetation from the banks of water-courses, and the treatment of infected individuals. The author summarizes the results obtained in Japan with these methods and concludes by stressing the efficacy of the procedure he considers to be the best, namely, the destruction of snails by chemical means. Naturally, this operation is not easy everywhere, since the ecology of the snails varies according to the region ; nevertheless research should be aimed in this direction. Two recently discovered compounds, dinitro-*o*-cyclohexylphenol and one of its derivatives, have proved to be very effective not only against snails but also against eggs and cercariae. These compounds are very expensive, however, and intensive efforts should be made to find a low-priced chemical which is not dangerous for man. According to the author, the solution to the problem of bilharziasis must be sought in this direction.

PLAGUE CONTROL IN TARANTO, ITALY, IN 1945

After a respite of about half-a-century, plague reappeared at Taranto in September 1945—a time when the health service of the port was disorganized by war. The administration of some ports was in allied military hands and that of others had been handed back to the civil authorities who were themselves in the course of reorganization after the collapse of the former régime. Under such conditions, an epidemic might have had very grave consequences. When the first case of plague appeared, the British Army was using the port of Taranto for the evacuation of troops and equipment. During this period, sanitary measures were applied by the military services. Later, control was handed back to the civil administration and, at the same time, the Health Division of UNRRA was charged with carrying on the active functions of epidemic control.

In an article which has just appeared in the *Bulletin of the World Health Organization*,[1] K. H. Schulz, formerly of the Malaria Section of WHO, describes the course of the epidemic and the deratting campaign which was immediately undertaken.

Twenty-nine cases of plague were reported between 6 September and 29 November 1945, and there were 15 deaths. The disease occurred in both its bubonic and septicaemic forms, the latter being 100% fatal. Seven of the 29 persons affected had been vaccinated either two, eight, ten, or thirteen days before the appearance of the disease. Three of these vaccinated persons died.

The exact source of infection was never discovered. It is possible that plague had existed for a considerable time in a latent epizootic state in the dock area of the naval arsenal. Rags piled up in a shed in the arsenal were believed responsible, since the first cases were observed among persons who had worked nearby.

The first measures taken by the British Army medical services consisted of cleaning the suspect shed, DDT spraying, and deratting by means of baits poisoned with barium carbonate or red squill onion. A " DDT zone " was laid down around the danger area, spraying extending to a depth of two or three blocks, and DDT dusting centres were installed in neighbouring districts. These measures were followed by a general campaign against rodents, undertaken with the collaboration of UNRRA.

The author describes in detail the three cycles of the deratting campaign —carried out by means of baits containing zinc phosphide and arsenious oxide—which lasted until the spring of 1946. The whole of the town and port of Taranto was covered, an area of 7 square kilometres with a population of about 185,000. More than 5,000 rats were destroyed ; none of the 300 rodents examined was carrying plague bacilli.

[1] *Bull. World Hlth Org.* 1950, **2**, 675

In concluding his article, the author suggests that this successful campaign might well serve as a model for antirodent campaigns to be undertaken throughout Italy, particularly in the ports.

DDT AND SANDFLIES

Anti-anopheline campaigns using residual DDT have resulted in the destruction of other insects which are intermediate hosts or vectors of human parasites. It has been noticed for several years in Greece that the number of sandflies—which transmit sandfly fever and leishmaniasis—is considerably smaller after spraying. Mr Marshall Hertig of the Gorgas Memorial Laboratory, Panama, took part in a survey organized in Greece by the Interim Commission of the World Health Organization and the WHO mission in 1948 to determine the effect on sandflies of DDT-spraying campaigns against mosquitos. In an article in the *Bulletin of the World Health Organization* [1] he has summarized the results of observations made in Athens and its suburbs, in certain villages of Attica, and in Canea, Crete. His investigations also extended to Italy and Sicily. Mr Hertig concludes that spraying the interiors of dwellings with residual DDT ensures immediate and almost complete protection against sandflies. By repeating the spraying every year at the time these insects hatch, their number can be reduced almost to the vanishing point.

[1] *Bull. World Hlth Org.* 1950, **2**, 621

DETERMINATION OF SMALL AMOUNTS OF RESIDUAL DDT

In a recent article in the *Bulletin of the World Health Organization*,[1] Professor Maria E. Alessandrini of the Istituto Superiore di Sanità, Rome, describes a rapid and fairly sensitive method for the detection and determination of small amounts of DDT on sprayed surfaces. This colorimetric method, which is a modification of that devised by Schechter, Solovay, Hayes & Haller, can be easily used even in the field and with limited equipment. By means of a colour-scale, amounts of DDT between 0.0001 g. and 0.005 g. can be directly estimated according to the colourations obtained. The author explains the advantages and limitations of the method and

[1] *Bull. World Hlth Org.* 1950, **2**, 629

summarizes observations made during the thousands of analyses carried out over two years in various parts of Italy, especially in Sardinia, the Pontine marshes, and Sicily.

SERODIAGNOSIS OF THE TYPHUS GROUP OF FEVERS

Standardization of Tests

Thanks to recent methods for the culture of rickettsiae on the chick embryo, suspensions suitable for the serological diagnosis of infections of the typhus-fever group are now available. In this way it has been possible to distinguish between different types of fevers belonging to this group which give analogous reactions to the *Proteus* OX antigens and which consequently cannot be differentiated by the Weil-Felix test. At the same time, tests carried out with rickettsial suspensions have their limitations and may lead to erroneous conclusions. It would therefore appear desirable to combine the use of these two sets of tests and to employ each of them according to its relative usefulness.

These considerations introduce a note submitted to the WHO Expert Committee on Biological Standardization by Dr A. Felix, Director of the Central Enteric Reference Laboratory and Bureau, London, and published in the *Bulletin of the World Health Organization*.[1] The author reviews the advantages and disadvantages of the two types of antigens (rickettsiae and strains of *Proteus* OX). He comes to the conclusion that, contrary to the opinion of certain workers, rickettsial suspensions cannot at present replace *Proteus* OX antigens for carrying out routine tests. They are destined to supplement rather than to supplant them. Furthermore, it is not correct to say that tests made with rickettsiae are " specific " whereas those employing *Proteus* OX are not.

On various sides the need has arisen for standardizing the materials and methods used in serological tests for the diagnosis of the rickettsiae, whether of the complement-fixation, rickettsial agglutination, or Weil-Felix type. The standardization of these methods presupposes the adoption of " international serum standards ".

In the second part of his note, Dr Felix examines the question of international serum standards for *Proteus* OX agglutination tests. The author suggests the adoption of " standard agglutinating sera " for the agglutinations occurring in the presence of *Proteus* OX19, *Proteus* OX2, and *Proteus*

[1] *Bull. World Hlth Org.* 1950, **2**, 637

OXK. These sera could be prepared on a large scale in horses, using as immunizing material the alkali-stable " O " antigens of the corresponding *Proteus* X strains.

DIAGNOSIS OF TYPHOID AND PARATYPHOID A AND B FEVERS

Standardization of Agglutination Tests

The agglutination tests employed in the diagnosis of typhoid and paratyphoid fevers will continue to be used for a very long time, despite the advances made in other respects in techniques for isolating the bacilli. Moreover, these tests remain indispensable in epidemiological research, for the detection of inapparent infections and of germ-carriers. Thus the question of their standardization is still of considerable importance at the present time.

In an article published in the *Bulletin of the World Health Organization*,[1] Dr A. Felix discusses various methods used for carrying out these tests. He then traces the history of the standardization of the Vi-agglutination test by means of the " provisional standard serum ", and stresses the success of this method. In the last part of his article, the author approaches the problem of establishing serum standards for the H, O, and Vi-agglutination tests. It would probably be possible to standardize the H and O agglutination tests in a manner analogous to that used for the Vi-agglutination tests. The first step would consist of adopting international serum standards for the determination of the H and O agglutinins. " Standard agglutinating sera " could be prepared for : typhoid H agglutination ; paratyphoid-A H agglutination ; paratyphoid-B, specific H agglutination ; paratyphoid-B, non-specific H agglutination ; typhoid O agglutination ; paratyphoid-A O agglutination ; paratyphoid-B O agglutination ; typhoid Vi agglutination.

Co-operative research under the auspices of WHO should then make it possible to find out, by examination of these eight sera in laboratories all over the world, if they are suitable for use as international standards.

[1] *Bull. World Hlth Org.* 1950, **2**, 643

STANDARDIZATION OF LIVER EXTRACTS

The increasing use of preparations based on liver extracts for the treatment of pernicious anaemia necessitates the setting-up of an international reference standard for assaying the potency of these products. The WHO Expert Committee on Biological Standardization dealt with this question during its third session.[1] A note on this subject, submitted to the committee by Dr E. Lester Smith, has just been published in the *Bulletin of the World Health Organization*.[2]

The author mentions the three methods which can be used for the assaying of liver extracts : the clinical method for determining the potency of the preparations in the patient ; the biological method, making use of an experimental animal ; and, finally, the microbiological method which, as it is simpler and more accurate, is tending to supplant the preceding ones.

The microbiological method consists in evaluating the potency of various substances by the action they have on cultures of micro-organisms. For the assay of liver extracts, Dr Smith suggests the technique applied in the case of vitamin B_{12}, *Lactobacillus lactis* Dorner being chosen as the test organism. The author gives some details regarding this technique.

The microbiological method may readily be employed in routine practice. However, some reservations must be made as concerns the interpretation of the results. The majority of the micro-organisms utilized react not only to vitamin B_{12}, but also to other growth factors which may be present in liver extracts. This becomes of particular importance in the case of organisms which are sensitive to the action of thymidine or to that of other substances which are clinically inactive. Research has been undertaken with the aim of modifying this technique and introducing chromatography on paper before the microbiological test.

The second part of the note deals with the problem of the standard preparation. The author favours the adoption of pure crystalline vitamin B_{12} as standard in preference to liver extracts themselves. This choice would have the advantage, among others, of making it possible to express the potency of the standard preparation as a weight of crystalline vitamin B_{12}, thus avoiding the use of arbitrary units. However, certain difficulties arise : at present, only extremely small quantities of vitamin B_{12} are available, and the stability of this substance still needs to be tested. The author suggests means of overcoming these two disadvantages.

---

[1] *World Hlth Org. techn. Rep. Ser.* 1950, **2** ; see also *Chron. World Hlth. Org.* 1949, **3**, 141.

[2] *Bull. World Hlth Org.* 1950, **2**, 651

ANTIGENS IN SERODIAGNOSIS OF SYPHILIS

The discovery of cardiolipin antigens has given rise to renewed interest in serodiagnostic tests for syphilis. Comparison of the new with the old antigens has formed the subject of numerous papers, and several workers have recently shown the superiority of the new techniques. The results of investigations carried out by Dr A. Bekierkunst of the Dermato-venereological Clinic, University of Wroclaw (Poland) and Dr F. Milgrom of the Institute of Medical Microbiology, Warsaw, who have compared the complement-fixation reaction, using cardiolipin antigens, with the Kahn reaction, have just been published in the *Bulletin of the World Health Organization.*[1]

The two tests were applied to 260 sera taken from 240 patients suffering from syphilis and from 20 cases of suspected syphilis. The complement-fixation test was positive in 88.1% of cases, while the Kahn test gave 86.2% positive results. These figures, which are confirmed by other results, lead the authors to the conclusion that the complement-fixation test utilizing cardiolipin antigen is at least as sensitive and specific as the Kahn test.

[1] *Bull. World Hlth Org.* 1950, **2**, 687

PSYCHIATRIC EXAMINATION OF OFFENDERS

The conviction of an offender is intended to exercise retributive justice, to deter others from committing crimes, and to reform the criminal himself. Does it actually achieve these aims ? It is difficult to say. The number of crimes at present taking place in the world does not justify the belief that the methods of criminal justice employed have any very considerable preventive influence, nor that present methods for the treatment of crime bring about the reformation of the criminal. The development of medical science, sociology, and psychology during the first half of the twentieth century has made a significant contribution to the better understanding of offenders and their acts. Intuition and empiricism are gradually being replaced among jurists by the application of scientific principles. However, because of the already crowded curricula of law schools, judges and other persons responsible for the enforcement of criminal laws are without adequate training in the medical and behaviouristic sciences.

These are the preliminary observations made by Dr M. S. Guttmacher, Chief Medical Officer of the Supreme Bench of Baltimore, Md., USA, in

an article recently published in the *Bulletin of the World Health Organization*.[1] The author describes a plan for setting up scientific legal institutes for the scientific examination of offenders prior to sentence.

Such a scientific legal institute would comprise three divisions : social, psychiatric, and medical. The social division would be responsible for compiling socio-medical records of the case-histories of the offenders ; such records would be placed at the disposal of the authorities concerned. Furthermore, this division could provide, through social workers, a supervisory and aid service capable of playing an important part in preventing crimes. The psychiatric division would be concerned particularly with the examination of young offenders and of accused or convicted persons, at the request of the court, jury, public prosecutor, or counsel. The medical division would have the task of giving advice on medical problems (examination of injuries, determination of blood-groups, autopsies, etc.) to the court and its agents.

After describing the functions of these three divisions in detail, the author concludes by stressing that one of the duties of the scientific legal institute would be training legal personnel in the application of social and medical sciences to criminal justice. Dr Guttmacher believes that, despite the variety of legal systems throughout the world, the fundamental principles which he recommends could, after suitable adaptation to the systems of different countries, be widely applied.

The paper which has been briefly summarized here was presented to the World Health Organization in the form of a report, entitled " Plan for the scientific examination of offenders prior to sentence ", for submission to the Social Commission of the United Nations. The Expert Committee on Mental Health examined this report during its first session and " is in entire agreement with the general principles put forward in this proposal ".[2]

---

[1] *Bull. World Hlth Org.* 1950, **2**, 743

[2] *World Hlth Org. techn. Rep. Ser.* 1950, **9**, 26 ; see also *Chron. World Hlth Org.* 1950, **4**, 3.

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports have therefore been published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

Mexican National Institute of Cardiology

Dr H. Chevalier, médecin-assistant des hôpitaux de Paris, and formerly chief of the cardiology clinic at the Faculty of Medicine, has been studying the working methods of the National Institute of Cardiology in Mexico and visiting several cardiology centres in the USA. Dr Chevalier describes in his report the organization of the Institute, directed by Professor I. Chavez, the activities of which include scientific cardiological research as well as clinical work and teaching.

The Mexican National Institute of Cardiology examines more than 25,000 people annually. It has a hospital section of 120 beds divided among four separate services (men, women, children, surgery). Although its principal activities are concerned with the diagnosis and treatment of cardiovascular diseases, the Institute is also a centre of scientific research and teaching. The latter covers complete courses of preparatory study for the diploma of Doctor in cardiology, and also separate advanced courses of short duration in such subjects as electrocardiography. The Institute possesses considerable technical equipment for the conduct of these courses, and comprises the following departments : electrocardiography and phonocardiography, radiology and angiocardiography, haemodynamics, haematology, biochemistry, bacteriology, anatomo-pathology, biostatistics, and rheumatology. The electrocardiography department alone has four doctors, two internees, three technicians, and a secretary. The department of experimental physiology, which is part of the Institute although housed in a separate building, includes twelve research workers. Approximately one-third of the annual budget of the Institute is allocated to research work.

Dr Chevalier studied the organization of the Institute as a whole, and in particular that of the modern electrocardiography section. A course in this subject includes theoretical and practical training (reading of hundreds of electrocardiographic recordings) and experimental work. Dr Chevalier took part especially in experimental research on septal activation, coronary phlebitis, and septic pericarditis in the dog. He also observed experiments with a new cardiotonic drug, and with techniques for the exact calculation of the refractory period in auricular and ventricular and other forms of myocardia.

Members of all departments meet together periodically for the discussion of problems ; sessions are held on clinical anatomy and haemodynamics, and on surgical medicine —at which the implications of cardiovascular surgery are studied.

In the USA, Dr Chevalier visited the cardiology laboratory of Tulane Medical School and the physiology laboratories of Louisiana University, New Orleans, the cardiology department of Bellevue Hospital, New York University, and Dr Paul D. White's department at the Massachusetts General Hospital, Boston.

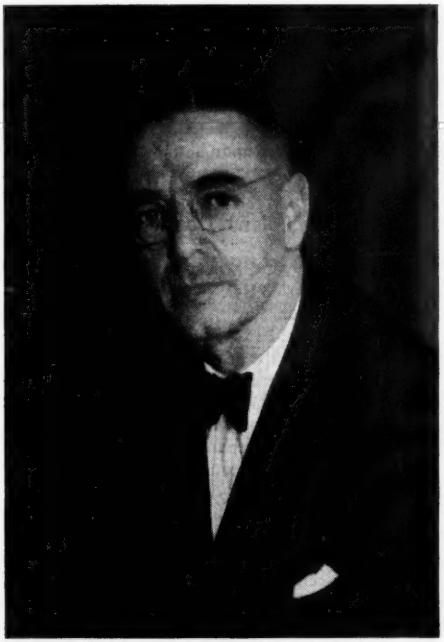
Notes and News

Dr Pierre Dorolle

Dr Pierre Dorolle, formerly Directeur du Service de la Santé publique au Haut-Commissariat de France en Indochine, has recently been appointed Deputy Director-General of WHO.

Dr Dorolle, who was born at Wassy, Haute-Marne, France, on 14 November 1899, studied medicine in Paris and at the Ecole de Médecine Navale et Tropicale in Bordeaux. After receiving his doctorate, with honours, from the Faculté de Bordeaux in 1924, he specialized in tropical medicine at the Ecole d'application du Service de Santé d'Outre-Mer at Marseilles, and obtained a very high place in the final competitive examination. He then served as medical officer in the colonial forces in Indochina, where he took part in a cholera-control campaign in 1927-1928.

FIG. 2. DR PIERRE DOROLLE



In 1930 Dr Dorolle obtained first place in the competitive entrance examination for the Corps des Médecins de l'Assistance médicale de l'Indochine, where he was destined to make his career and attain the highest rank. At first, he was assistant to the Inspecteur de l'Hygiène et de la Santé publique ; later, from 1934 to 1936, he held the post of chief physician of a hospital at Saigon, and after that a similar post at Hanoi, where he also taught clinical aspects of contagious diseases at the medical faculty. At the time of the cholera epidemic of 1936-37, he was in charge of the municipal health services of Hanoi and conducted a mass-vaccination campaign.

As an expert of international repute, Dr Dorolle participated in the work of the Epidemics Commission of the League of Nations in China in 1937. He was first in charge of the Canton area ; later, he was appointed chief technical expert and representative of the Secretary-General of the League of Nations to the Chinese Government. However, he still continued to be very active in campaigns against epidemic diseases, such as cholera, plague, and malaria.

In 1940 Dr Dorolle was recalled to Indochina by his Government to assume direction of the psychiatric hospital of Cochin-China ; later, he held a number of important posts

in public-health administration. In 1943, he was appointed Directeur de la Santé de l'Annam and restored the health services which had been disorganized by bombing and blockade and, under conditions made difficult by lack of drugs and supplies, directed the campaigns against serious epidemics of typhus and plague in the Haute-Région and epidemic outbreaks of malaria. Interned in 1945 by the Japanese, he organized health services and campaigns to control cholera and diphtheria in the concentration camp of Hue. After the liberation he resumed his post of Directeur de la Santé de l'Annam but was later called to take over direction of the Service de la Santé publique du Haut-Commissariat de France.

Dr Dorolle has taken part in a number of missions in equatorial Africa, India, Burma, and Java. Since the end of the war, he has participated in several international conferences on food hygiene at Singapore, Baguio, Bangkok, and Rangoon. In 1950 he was a member of the French delegation to the Third World Health Assembly.

Dr Dorolle is the author of a number of works on the pathology of tropical diseases, contagious diseases, tropical syphilis and its nervous and cerebral complications, epidemiology, rural sanitation, forensic medicine, and food hygiene, with special reference to the Indochina area where he conducted the first systematic investigations on nutrition. In recognition of these works, Dr Dorolle was elected to membership of the Société de Pathologie exotique in Paris in 1936. He is also a corresponding member of the Ecole française d'Extrême-Orient.

Dr Dorolle has received the decorations of the Légion d'Honneur, the Croix de Guerre avec palme, and the Médaille d'argent des Epidémies ; in addition, he holds high honours conferred upon him by the Governments of Cambodia, Laos, and Viet-Nam.

Poland Decides to Withdraw from WHO

H.E. Julian Przybos, Minister of Poland in Bern, has informed Dr Brock Chisholm, Director-General of WHO, of his Government's decision to withdraw from the World Health Organization.

In his letter, dated 15 August 1950, the Minister asserts that WHO has given " proof of its lack of faith in the principles which should guide its work, as well as of its complete surrender to the imperialistic States, and in particular to the United States " and states that " the Government of the Republic of Poland declines to take any responsibility for the orientation of the activities of WHO and for their submission to the imperialistic policy of the powers preparing a new war... ".

As a war-devastated country, Poland has received many forms of assistance from WHO. A medical liaison officer was maintained in Poland until the autumn of 1948 to advise the national health administration and to arrange for WHO services.[1] Poland received technical aid from WHO in its nationwide campaign against venereal diseases,[2] and was assisted in the organization of a tuberculosis control scheme.[3] WHO participated in the BCG-vaccination campaign in Poland.[4] A consultant visited Poland to advise workers on streptomycin therapy and to work out a uniform scheme of reporting results,[5] and a consultant on x-ray technology conducted demonstrations and assisted in the publication of a manual on x-ray techniques.[6] Of a total of 800 fellowships awarded by WHO, 119 were received by Polish physicians ; $26,000 was made available for this purpose for 1950.

Other assistance included the supply of medical literature. So far Poland has received 704 medical books, 95 microfilms, and subscriptions or renewals to 241 periodicals. A medical team, composed of specialists from various countries, visited Poland under

---

[1] *Chron. World Hlth Org.* 1947, **1**, 74; 1948, **2**, 230
[2] *Chron. World Hlth Org.* 1949, **3**, 29, 285
[3] *Chron. World Hlth Org.* 1948, **2**, 120
[4] *Chron. World Hlth Org.* 1948, **2**, 34 ; 1950, **4**, 125
[5] *Chron. World Hlth Org.* 1949, **3**, 132
[6] *Chron. World Hlth Org.* 1948, **2**, 66

the joint auspices of WHO and the American Unitarian Service Committee.[7] This team gave courses throughout the country and demonstrated some of the latest techniques in medicine and surgery. The team provided medical equipment and literature to Polish scientific centres and medical schools.

Provision had been made in 1950 for supplies, equipment, and staff for a biochemistry training centre in Wroclaw and a venereal disease control training centre in Warsaw.[8]

Manual for Tuberculosis Control Workers

A *Manual of Information for Workers of Tuberculosis Control Centres, China*, has been prepared by WHO consultants in China, and copies in the English and Chinese languages are now available. This manual gives a comprehensive account of modern methods adopted in the control of tuberculosis, with particular reference to mass chest surveys and BCG vaccination, and deals in detail with the responsibility and activity of the tuberculosis control worker. It will be specially useful to workers in countries with undeveloped control programmes.

The manual was prepared by Dr I. M. Lourie, Tuberculosis Consultant, and Miss A. L. Eggestein, Nurse Consultant, both formerly with the WHO mission in China.

Spanish and French Editions of the Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death

Volume 1 of the *Manual de la Clasificación Estadística Internacional de Enfermedades, Traumatismos y Causas de Defunción* is now available. This is the first publication of its kind in Spanish and represents a significant contribution to the improvement of comparability of medical statistics, especially since the *Manual* will be used as such by many of the Spanish-speaking countries, rather than merely as a basis for the preparation of national manuals.

Volume 1 of the *Manuel de Classement Statistique International des Maladies, Traumatismes et Causes de Décès* has also been published.

The *Manual* provides for the first time a single list for coding both diseases and causes of death and, in addition, includes an extensive Tabular List of Inclusions, which gives diagnostic terms defining the content of each category of the list, and a comprehensive Alphabetical Index. Also included are WHO Regulations No. 1 regarding nomenclature with respect to diseases and causes of death, as adopted by the First World Health Assembly and put into force on 1 January 1950.

Volume 1 of the English edition of the *Manual* was published in 1948,[9] and Volume 2, the alphabetical index, appeared in 1949. The two volumes of the *Manual* are available at a price of $6.00.

---

[7] *Chron. World Hlth Org.* 1948, **2**, 158

[8] *Chron. World Hlth Org.* 1950, **4**, 154

[9] *Chron. World Hlth Org.* 1949, **3**, 17

Views on WHO

Challenge of Malnutrition

An editorial in the FAO European Bulletin, *Food and Agriculture* (1949, **2**, 79), emphasizes the importance of nutrition in the WHO programme and the need for a close co-operation between these two specialized agencies of the United Nations :

" While the great need for curative treatment is today still a tacit admission of the failure so far, in many respects, of Preventive Medicine, it has been refreshing to observe how WHO as the torchbearer for the coming New Order in Medicine is not only laying more and more emphasis on Prevention but feels that even Prevention is still too negative a view and that public health services should become *promotive* (nothing less than that) and that as soon as the exceptionally bad disease areas in the world are under control, the necessary shift of emphasis from disease to health and the factors that promote it, will readily come to pass.

" As FAO's strongest and most necessary link with WHO will probably always be in the field of nutrition and food production, FAO would like to believe that in WHO's very appropriate definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', the need for proper nutrition as a basic conditional factor to it all was so strongly implied that it required no special mention; that Nutrition, the 'stone discarded by the builders' will in the New Order in Medicine become an important foundation stone.

" Jointly, it is hoped, our two Organizations will see in our two most important enemies, Malnutrition and Disease, not the struggle but a CHALLENGE... to prove to the world that a programme of better nutrition is less costly than one involving the dealing with people who are weak or diseased, unhappy and unproductive ; that, reckoned in terms of low vitality, impaired efficiency, actual sickness and hospitalization, malnutrition is a tax which no nation on earth—not even the United Nations—can go on paying."

Mental Health

In connexion with the first report of the WHO Expert Committee on Mental Health, the *Medical Officer*, London (1950, **83**, 249) comments :

" We are increasingly hearing about mental health in these days. One reason for it may be the greater incidence, or at least ascertainment, of frank psychiatric illness. Another may be the emergence of the concept of psychosomatic medicine, while yet a third, and perhaps the most important, is the recognition that human society both in this country and generally is in a profoundly unstable state... That the medical officer of health is involved in this question is undisputed, though where he stands relative to it is more obscure. His statutory duties are limited to ascertainment and disposal, his permissive power to the care and after-care of the psychiatric sick or convalescent within the community, while his wider interest is with the prevention of mental as of organic disease and the preservation of total health. The subject is complex and difficult.

" The World Health Organisation has, rightly enough, entered this field and the Report on the First Session of the Expert Committee on Mental Health lies before us. The opinion here unequivocally expressed is that preventive work is in urgent need of development and extension and that the medical officer of health is the proper person to undertake it as an ordinary part of his duties. If necessary, he should receive further training to equip him to ' provide ', in the words of the report, ' the generalship for preventive mental health work. ' He will control a team, of which the most valued member is likely to be the public health nurse ; another addition, he may reflect, to the already onerous burden of the health visitor. The suggestion is not that he be turned into a psychiatrist but rather that he should concern himself, to quote the report again, with ' the recognition and eradication of factors in the community

which are harmful to the healthy psychological development of individuals.'

" So far, so good. WHO at least seems to recognise the place and importance of the medical officer of health. But when the report goes on to consider the practical steps involved, a much less satisfactory picture is presented. What, after all, is mental health ? WHO admits that there is no constant measure of it because it varies with the cultural patterns of racial and national groups, and among different sections within them. No attempt is made here to indicate a basic design for healthy mental living for Everyman and how he should be able at least and in general to attain content and often or sometimes happiness and joy...

" The trouble with the cultural offshoots of the United Nations is that, for all they are predominantly Western, they have so little use for the traditional wisdom of the West. Indeed, the pattern of conduct and attitude to the world that lead to integration of personality are to be found in recognisable form everywhere, their witness borne by the philosophers and prophets of all peoples. Let WHO fairly tackle the problem of what are the essentials of mental health, and then we shall be better able to devise the administrative procedures necessary to foster their growth."

WORLD HEALTH ORGANIZATION
TECHNICAL REPORT SERIES

(Separate editions in English and in French)

	Price
1. Expert Committee on the Unification of Pharmacopoeias : report on the fourth session	9d $0.10
2. Expert Committee on Biological Standardization : report on the third session	1/6 $0.20
3. Expert Committee on Biological Standardization : report of the Subcommittee on Fat-Soluble Vitamins	9d $0.10
4. Expert Committee on Insecticides : report on the first session	2/3 $0.30
5. Expert Committee on Health Statistics : report on the first session	9d $0.10
6. Active immunization against common communicable diseases of childhood	1/3 $0.15
7. Expert Committee on Tuberculosis : report on the fourth session	1/3 $0.15
8. Expert Committee on Malaria : report on the third session	2/3 $0.30
9. Expert Committee on Mental Health : report on the first session	2/3 $0.30
10. Expert Committee on Environmental Sanitation : report on the first session	2/- $0.25
11. Expert Committee on Plague : report on the first session	1/6 $0.20
12. Expert Committee on the Unification of Pharmacopoeias : report on the fifth session	9d $0.10
13. Expert Committee on Venereal Infections : report on the third session	1/6 $0.20
14. Expert Committee on Venereal Infections : report of the Subcommittee on Serology and Laboratory Aspects	2/- $0.25
15. Venereal-disease control in the USA : report of the WHO Syphilis Study Commission	3/6 $0.45
16. Joint FAO/WHO Expert Committee on Nutrition : report on the first session	1/3 $0.15
17. Joint OIHP/WHO Study-Group on Bilharziasis in Africa : report on the first session	9d $0.10
18. Joint OIHP/WHO Study-Group on Cholera : report on the third session	*To be published*
19. Yellow-Fever Panel : report on the first session	9d $0.10
20. Joint ILO/WHO Committee on the Hygiene of Seafarers : report on the first session	9d $0.10
21. Expert Committee on Drugs Liable to Produce Addiction : report on the second session	9d $0.10
22. Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel : report on the first session	*To be published*
23. Joint OIHP/WHO Study-Group on African Rickettsioses : report on the first session	
24. Expert Committee on Nursing : report on the first session	
25. Expert Committee on Health Statistics : report on the second session. Including reports of the Subcommittee on the Definition of Stillbirth and Abortion, the Subcommittee on the Registration of Cases of Cancer, and the Subcommittee on Hospital Statistics	2/- $0.25

	Price	
26. Expert Committee on Antibiotics : report on the first session . . .	9d	$0.10
27. Expert Group on Prematurity : final report	9d	$0.10
28. Expert Committee on Rabies : report on the first session	*To be published*	
29. Expert Committee on the Unification of Pharmacopoeias : report on the sixth session		

Bulk Orders

A discount of 20% will be given to health organizations for orders of 100 copies or more. Such orders should be sent direct to the World Health Organization, Sales Section, Palais des Nations, Geneva, Switzerland.

INTERNATIONAL DIGEST OF HEALTH LEGISLATION

(Separate editions in English and in French)

The *Digest* contains reproductions of or extracts from national laws and regulations dealing with public health and related subjects, as well as a list of current legislation on such topics.

Subscription per volume	25/-	$5.00
Price per single copy	6/3	$1.25

WEEKLY EPIDEMIOLOGICAL RECORD

(Bilingual : English and French)

This publication, intended for national health-administrations and for health services at ports and frontiers, contains notifications concerning diseases designated as " pestilential " in the International Sanitary Conventions, as well as other information about the application of these Conventions.

It is not sold separately, but can be obtained in conjunction with the *Epidemiological and Vital Statistics Report* (see below).

EPIDEMIOLOGICAL AND VITAL STATISTICS REPORT

(Bilingual : English and French)

The *Report* is published monthly and contains statistics on infectious diseases and birth- and death-rates, and articles on epidemiological and demographic subjects.

Subscription for 1950	25/-	$5.00
Price per single copy	2/6	$0.50
Annual subscription, including the *Weekly Epidemiological Record* . .	£2	$8.00

OFFICIAL RECORDS
OF THE WORLD HEALTH ORGANIZATION

(Separate editions in English and in French)

This series contains the reports and relevant documents of the World Health Organization and its governing bodies.

Recent numbers :	Price
21. Second World Health Assembly	16/9 $2.25
22. Report of the Executive Board, fourth session	3/9 $0.50
23. Proposed programme and budget estimates for the financial year 1 January-31 December 1951	11/- $1.50
24. Annual report of the Director-General to the World Health Assembly and to the United Nations, 1949	6/- $0.75
25. Report of the Executive Board, fifth session—Part I	3/9 $0.50
26. Report of the Executive Board, fifth session—Part II	6/- $0.75
27. Financial report, 1 January-31 December 1949, and report of the External Auditor	1/9 $0.25

In preparation :

28. Third World Health Assembly
29. Report of the Executive Board, sixth session

MANUAL
OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES, INJURIES, AND CAUSES OF DEATH :

SIXTH REVISION OF THE INTERNATIONAL LISTS OF DISEASES AND CAUSES OF DEATH, ADOPTED 1948

Bulletin of the World Health Organization, Supplement 1

Volume 1 :

Introduction

List of three-digit categories (detailed list)
Tabular list of inclusions and four-digit subcategories
Medical certification and rules for classification
Special lists for tabulation
Suggested form of multiple-cause tabulation
Regulations

Volume 2 :

Alphabetical index

Price per set 30/- $6.00